MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, December 14, 2001
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Public comment III

MR. HACKBARTH: Okay, time for the public comment period, which will last 15 minutes.

MS. CLARK: Hello, my name is Shelly Clark and I'm representing National Renal Administrators Association today. I'm their president. I'm from Roanoke, Virginia and manage several rural and metropolitan dialysis facilities. I worked for 10 years in a hospital-based system and closed three of those dialysis units. I worked for 10 years in physician-owned clinics and helped them open some rural health care centers, and I have closed or help closed to two of those, and now manage some of these same dialysis facilities for a chain after we were acquired.

So I'd like to make just a few points on Ms. Ray's presentation. It's interesting to me that whether or not I have to close any more dialysis facilities may rest with you.

I'm not an economist. I'm an R.N. However, I can deliver a clear message from all providers. As Ms. Ray has already identified, the composite rate is not covering our cost of care. The reimbursement is fixed except for congressional changes in '91, '99, and 2000. We've had a history of fold-ins with meds and labs, unfunded regulatory mandates, technology advancements where we don't get any increases, improved quality of care, and soaring staffing costs with no annual updates.

As a note of correction to her presentation I'd like to note, facilities themselves cannot bill for lab. Only labs can bill Medicare for the labs. So the 4 percent factor that she mentioned may need to be revisited by MedPAC.

Everyone analyzes teh cost reports, as I do, and Ms. Ray noted that they do not include medical director and administrative salaries. We prepared a handout for you that on page 9 will clarify some of those percentages I think you asked about. Cost reports also do not include bad debt for non-composite rate ancillaries, or the effect of Amgen's two-year price increase for EPO, which you're aware of.

It is very important that I make these notes on separably billable drugs and margins. Oral drugs are very costly to the beneficiary. When we write our patients these prescriptions, they cannot afford to get them filled. IV meds are where we can steer the patient's quality of care.

There was an instance a few years back where the IV iron manufacturer had to recall the drug. We have evidence that we went back to oral medications, our quality went down the tubes

for our anemia management for our ESRD patients. We'd welcome the opportunity to get some of this statistically important information back to you to look at before you make any recommendations.

It would be also very premature to make any recommendations about including the new form of EPO in a bundle or in the composite rate in that we've not even seen that in the market yet. Until it's there, working, and we can analyze it statistically, it's too premature to include.

So in summary, dialysis providers have been unjustly compensated as compared to other health care providers. I found it very interesting on the discussion of rural hospitals and some of the hold harmless and other factors that they have to protect them. All the dialysis facilities have had is an exception request processed that I have some personal experience with. It's difficult, it doesn't work well, and it's now been taken away from us. So unless that's restored we're still in trouble, as you can see from the lack of the data points she had on the one slide with our decreasing margins.

Please review our recommendations we'd like to have you consider. We want you to look at the true definition of what's in the existing composite rate and do a price recommendation based on the frequency and cost of what we really do. It's critical we get this in 2003. We must have annual update mechanisms calculated in. I'm not an economist and it's very complex how you do that, but it's critical to us.

Going forward, then we can explore what the CMS is going to report this coming year. We would like to work with the industry on perhaps looking at an expanded bundle to protect us from more crisis in the industry that we're looking at now.

Thank you.

MR. LEWIN: Hello, I'm Howard Lewin and I represent the Renal Leadership Council. First, a piece of information. Some data from three large chains is that currently 77 percent of the patients within the large chains are Medicare primary covered, and 23 percent have commercial insurance. Some of the patients with commercial insurance are Medicare eligible, but since commercial insurance does typically pay dramatically more than Medicare there is no secondary payment there.

What I'd like to do now is address the point about is the current payment reasonable. There was some data presented earlier today that in 1999 the combined payment was 7 percent above cost except for medical director fees and unreimbursed bad debt on non-composite services.

Medical director fees have risen dramatically over the past

10 years, primarily because the number of nephrologists in practices remain very constant, and the number of dialysis centers has risen dramatically. So increasingly, nephrologists have a lot of choice about where they would provide medical director services. At this point the $250 an hour number is very close to the typical medical director reimbursement within the large chains.

One example of unreimbursed bad debt is in the area of Epogen. Currently, large chain providers do pay about $8 per thousand units for Epogen, and the Medicare payable is also $8 per thousand for Epogen. That $8 cost for the providers does not include any G&A cost associated with drug delivery and other related costs.

The reasons that the chains look financially healthy today is that -- and this is data for two large chains -- is that the ratio of non-Medicare and Medicaid reimbursement to Medicare-Medicaid currently is 1.83. That dramatic difference in the reimbursement rates for non-Medicare payers compared to Medicare drives the industry's profits today.

The implications of this large gap are, first, that new centers are increasingly opening where there are many more non-Medicare patients than the national average. Again, this is data for three chains. The non-Medicare percentage in the 71 new facilities opened in 1999, 2000, and 2001 -- I have two years of data -- is 31 percent non-Medicare in 2000 and 36 percent non-Medicare in 2001. This is, again, compared to 23 percent non-Medicare overall.

Additionally, for facilities closed within the same three chains for 1999, 2000, and 2001 -- and this is in the case of the 40 facilities closed -- the percentage of patients that had Medicare primary is 84 percent. Medicare patients are increasingly in danger of losing access. Traveling long distances three times a week for treatments that increasingly are at a very inconvenient time, either very, very early in the morning or very, very late at night, in areas where there are the vast majority of Medicare patients compared to the national average is increasingly what's happening based on the current payment system that we have in place.

Thanks.

MS. CUERVO: Good afternoon. My name is Acela Cuervo and I am the general counsel for the American Association for Home Care. We represent home health agencies and suppliers of home medical equipment. There is a payment issue that pertains to home oxygen services that I would like to make you aware of. It truly is not unlike the issue of the ESRD update.

The BBA reduced payment for home oxygen services by 30 percent, and then froze the update through 2002 and all subsequent years. This means that Medicare payment for home oxygen services are indefinitely frozen at 70 percent of the level that they were at in 1997. The BBRA did authorize small payment updates for home oxygen for 2001 and 2002, but these updates are temporary. So at the end of 2002 the payment levels for home oxygen will revert back to what they were, 70 percent of what they were in 1997.

This has tremendous implications for Medicare home oxygen patients, which as many of you might know, tend to be the sicker and more elderly frail of the Medicare beneficiaries. As costs for delivering quality home oxygen services rise over time but the Medicare reimbursement remains flat it becomes increasingly difficult for our members, who are -- the vast majority of suppliers tend to be small, independent companies -- to provide the level and quality of care that the Medicare beneficiaries need.

We believe that it's very important that Congress restore the home oxygen services benefit to make it eligible for a CPI update beginning in 2003 and all subsequent years. We would welcome the opportunity to work with you and provide you with further information on this issue.

Thank you very much.

MR. GRAEFE: Thank you, Glenn. Fred Graefe of Baker & Hostetler on behalf of Invacare, the largest manufacturer of home medical equipment. It's headquartered in Cleveland. I'm here to support the application of Acela and her trade association. Invacare is a member of that trade association, and it is critical for Invacare's customers, which is, as I said, the largest manufacturer of home medical equipment including oxygen systems.

The final point, that Invacare is not only the largest manufacturer in this country, but it's also the largest creditor for its industry. With the recession and post 9-11 and all those bank credit crunch, it's exceedingly important that, we believe, that the Commission look at this issue so that you can report to Congress next year in a timely fashion when this issue will certainly come up.

We look forward to working with the commissioners and your staff. Thank you very much.

MS. FISHER: Karen Fisher with the Association of American Medical Colleges. Just a quick point on the outpatient arena. It seemed you were circling around a little bit the issue of a potential fee schedule by being above a threshold amount. It

seems very akin to almost modifying the current outlier provision on the outpatient side. You still include hospital-specific costs with the outlier, but there is an option there of looking at the outlier as a potential option for dealing with the pass-through issue.

Now, of course, the current outlier pot would not be enough money to deal with this issue. But I think that's another option you might want to think about as you move forward.

Thank you.

MS. MENSCH: I'm Stephanie Mensch from the Advanced Medical Technology Association. We represent device manufacturers. I just wanted to reiterate a couple of points, indeed that one of your staff members made. That is, the dearth of good data in the outpatient setting to help construct exactly what the policy should be on some of these things. That was one of the reasons that AdvaMed supported the concept of a pass-through program in the beginning, because CMS when it constructed the original APC rates did not recognize device costs in it. They're still have problems with it. The reason you saw 2.5 percent to 13 percent in the fold-in this year is because the base rates just haven't reflected the cost of devices and technology.

We believe that with continuing the pass-through payment program after 2003 will allow for new technology in all hospitals that require it.

One other thing I just wanted to clear up real quickly, the pass-through program is not a pass-through directly to the device manufacturer. It's a way to assist hospitals to get paid for the devices. It goes to the hospitals. It doesn't go to the manufacturers.

The other point is that marking up devices is not as easy as it may sound on the surface. The hospitals are constrained by the charges that they give to all of their payers, and each year CMS goes back and looks at what their charges and will adjust their cost-to-charge ratio. So it does have future impact.

Anecdotally, we believe that some of the higher cost devices are not marked up as high as other items that the hospital may mark up. So it's a very complex thing.

Finally, as you know, we do not support separating out and developing a fee schedule for devices under the APCs. We believe they should be put into the bundle, the bundled package of the APCs, and that there should be a transition year to allow collection of data -- not only price data, but the utilization and matching the APCs.

Thank you.

MR. HACKBARTH: Thank you all very much. We're adjourned

until January.

[Whereupon, at 12:46 p.m., the meeting was adjourned.]